Uljana Scott, MD
Shine Bright Pediatrics
20110 SW Alexander St
Beaverton, OR 97003
(503) 649-5257 Phone
(503) 259-9582 Fax

Please read carefully.

Financial Agreement:

Shine Bright Pediatrics works with most major insurance plans. Each insurance plan and benefits are different and it is important for you to contact your insurance company directly with any questions regarding your benefits and to understand your financial responsibility at the time of service.

We follow national guidelines, such as AAP Bright Futures, but not all insurance plans cover the recommended services, and you will be responsible for services not covered by your insurance plan.

Copayments and Deductibles.

Depending on your insurance policy, a copayment and/ or deductible may be required at the time of service. These payments are contractual requirements from the insurance company and cannot be written off by the clinic.

Copayments are always due at the time of service.

If you have a High Deductible Health Plan and have not yet paid your full deductible, it is likely that any non-preventive services will require payment at the time of those services are rendered.

Out of Network insurance.

We are happy to discuss options available, so that we may provide care for your child(ren).

Patients without insurance coverage.

We are happy to work with families that prefer to pay directly for services or do not have insurance. If you do not have insurance coverage, payment is due at the time of service. A time of service discount will be applied to the bill.

Payment options.

We accept cash, checks and major credit cards.

We encourage you to register and pay your bills through Patient Portal.

A minimum of $10.00 may be added to unpaid balances over 30 days old.

For checks returned due to insufficient funds, a $25.00 charge may be added.

_____ _____ _____

Child's name Date of Birth Initials

Dr. Scott understands that sometimes financial situations can become difficult. Please call and make **payment arrangements if needed** and keep in touch if those arrangements cannot be met. If not kept informed, accounts may be given to a collection agency with a minimum $30.00 collection fee. If this occurs, Dr. Scott may need to relinquish care on all the children in the family.

Credit Card on File.

_____ We require a valid credit card on file with practice's secure payment service.
We will notify you about any balance due as determined by your insurance company and as shown in the Explanation of Benefits they send to you.
Your card will be charged the amount due if we do not receive payments within 30 days.
You will receive notification once your card is charged.
If you would like to make payment arrangements, please discuss this with us in advance.
If you delegate another person to bring your child to an appointment, your card will be used for payments due at that appointment.

_____ I understand and agree that I am financially responsible for all services rendered. I understand that the office will bill the insurance company that I have provided to them. I also understand that I am responsible to update my insurance information if any changes occur. Any services rendered that are not covered by my insurance company are my responsibility.

_____ I hereby give my permission for Dr. Scott to treat the previously named child(ren) for routine care and in my absence to administer emergency care as deemed necessary by the doctor.I authorize payment of medical benefits to Dr. Scott for services provided. I also authorize the release of any medical or other information necessary to Dr. Scott to process my child's insurance claim.

No Show Fee.

Missing an appointment without giving prior notice denies other patients that appointment time. We require notice of **at least 24 hours** for cancellations. Failure to notify the clinic in a timely manner may result in a no-show fee of $25. Repeated no-shows may result in limits on the times of day appointments can be scheduled, limits on numbers of children who can be seen in a given time frame, or discharge from the practice.

_____ _____

Patient/ Child's name Date

_____ _____

Parent/ Guardian name and signature Relationship to patient